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INITIAL CONSULTATION PACKET

(Updated **07-01-22**)

Thank you for downloading this packet.

Please print the entire packet and complete each form in advance of your appointment.

Should questions arise in reviewing this information, please note them and we can discuss during your appointment.

Contents:

1. Client Information
2. Informed Consent
3. HIPPA Form
4. HIPPA Notification Form
5. Credit Card Payment Information

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BACKGROUND INFORMATION

Name: _____ Date: _____

Address: _____

_____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Email: _____

Where is the best place to leave a message? _____

Age: _____ Sex: _____ Date of Birth: _____

Relationship Status: _____ Racial/Ethnic Group: _____

Occupation: _____

Educational Level & Institution: _____

In Emergency, notify:_____ Phone: _____

Please briefly describe your reason for seeking services today:

Please briefly describe what you would like to accomplish in therapy:

Please respond to the following items by marking an “X” next to all that apply.

I am experiencing or have experienced the following (in the past year):

Currently	**In the past year**	
_____	_____	Sleep disturbances
_____	_____	Appetite disturbances
_____	_____	Difficulty concentrating
_____	_____	Loss of interest in hobbies, work, school, ex, etc.
_____	_____	Depressed mood
_____	_____	Decreased energy level
_____	_____	Increased energy level
_____	_____	Feelings of hopelessness
_____	_____	Feeling overwhelmed
_____	_____	Isolation/social withdrawal
_____	_____	Feeling agitated/pressured to act
_____	_____	Feeling worthless
_____	_____	Feeling euphoric
_____	_____	Panic attacks
_____	_____	Anxiety and/or stress
_____	_____	Relationship concerns
_____	_____	Alcohol use
_____	_____	Other drug use

Currently	In the past year	
_____	_____	Body image concerns
_____	_____	Excessive dieting or restrictive eating
_____	_____	Binge eating or purging
_____	_____	Excessive use of laxatives or exercise
_____	_____	Self-injurious behaviors (e.g., cutting, burning, hitting oneself)
_____	_____	Thoughts about ending my life
_____	_____	Thoughts about ending someone else's life
_____	_____	Impulsive behaviors (e.g., gambling, spending sprees, sexual, violence)
_____	_____	Obsessions and/or compulsions
_____	_____	Physical abuse
_____	_____	Sexual assault or abuse
_____	_____	Disturbing thoughts
_____	_____	Grief/loss
_____	_____	Family stressors
_____	_____	Work or career concerns
_____	_____	Financial concerns
_____	_____	Sexual concerns
_____	_____	Adjustment difficulties (e.g., moving, new job, other transitional issues)
_____	_____	Other: Please describe _____
		_____

MEDICAL INFORMATION

Treating Physician: _____

Physician's Phone: _____

Are you currently taking any medications? _____

Name(s) of medication(s): _____

_____

Dose and frequency of each: _____

_____

PREVIOUS PSYCHOLOGICAL TREATMENT

Have you ever been in counseling before? Y / N

If yes, please complete the following:

Dates of Treatment	**Reasons**	**Was it helpful?**

Have you ever been hospitalized for psychiatric reasons? Y / N

If yes, please complete the following:

Dates of Hospitalization	**Reasons**	**Length of Stay**

FAMILY INFORMATION

Please list your family members:

Name	**Age**	**Relationship**	**Occupation**
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

Has any family member ever been treated for mental health concerns? Y / N

If yes, please describe:

How did you learn of my practice?

_____ Website (DupontTherapy.com)

_____ Psychology Today website

_____ Google business listing

_____ Google advertisement

_____ University counseling center

_____ Doctor's referral (Name? _____)

_____ Friend, family member or colleague

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INFORMATION ABOUT SERVICES

Welcome to my psychotherapy practice. This document contains important information about my services and business policies. Psychotherapy works because of clearly defined rights and responsibilities held by each person. This frame helps to create a safe environment intended to support and facilitate our therapeutic work. As a client in psychotherapy, you have certain rights that are important for you to be aware of. Please read this document carefully, as this document will represent an agreement between us. If you have any questions about the information contained within, please note them so that we may discuss them at our next meeting.

INITIAL CONSULTATION

I consider our first one to three sessions an initial consultation for both of us. This is a time for me to learn more about you, your history and therapeutic needs, and an opportunity for you to decide if you feel comfortable working with me. Because psychotherapy involves a significant investment of time, money, and energy, it is important that you take time to select a therapist who is right for you. I do not agree to work with clients who, in my opinion, I am unable to provide the best services to meet their clinical needs. In such cases, I will offer you a referral(s) to other providers in the community.

APPOINTMENTS

My sessions last for 50 minutes and if we agree to work together, we will choose a regular time to meet that will be set aside for you each week. That hour will be considered your time. Because I tend to make appointments well in advance, I require 48 hours notice for the cancellation of a session. If you give me less than 24 hours notice of a cancellation, you may either reschedule within the same week (if I have time available) or pay for the session. If you miss a scheduled appointment without notifying me in advance, you will be charged your full fee.

BILLING AND PAYMENT

The current charge for a 50 minute individual psychotherapy session is **$220**, and **$250** per couples counseling session. This charge will remain constant except for possible annual adjustments. I will provide you with a bill during your last session of each month. Your full bill is to be paid at that time unless we have made other arrangements. There will be a $25 service charge for all returned checks.

INSURANCE

Insurance companies are required by D.C. law to provide mental health coverage. The details of this coverage vary from policy to policy. It is your responsibility to determine how much coverage you may have and what steps you must take to activate that coverage. Although I do not directly deal with insurance companies, my monthly bills provide all the information that an insurance company would generally need in order to reimburse you for services.

CONTACTING ME

I am often not immediately available by telephone, since I am often meeting with other clients when in my office. When I am unavailable, my telephone is answered by voicemail that I monitor frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your primary care physician or go to the nearest emergency room.

CONFIDENTIALITY

The law protects the privacy of all communications between a client and a psychologist. Our sessions will be completely confidential unless:

1. I have good reason to believe that you will harm another person;
2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this;
3. If I believe that you are in imminent danger of harming yourself;
4. If you sign a written consent to have information released;
5. If consultation with another professional is sought for the purposes of ensuring or enhancing the quality of services provided, in which case your anonymity will be maintained;
6. If I receive a court order mandating that I release treatment records.

Other than the above exceptions, our therapeutic relationship and the information discussed in the context of that relationship is privileged information and will not be disclosed to anyone else. In the case that confidentiality must be broken, however, I will make every effort to fully discuss this with you before taking any action, and I will limit my disclosure to what is necessary.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. Please see the Notice of Policies and Practices to Protect the Privacy of Your Health Information, a separate policy statement and consent form that describes my procedures regarding my professional records.

ENDING THERAPY

Ideally the decision to end therapy will involve a mutual assessment of your needs, a review of your progress, and the selection of an agreed upon ending date. If you feel that you are ready to end treatment, or if you are concerned or dissatisfied with our work, I ask that you please raise these matters in session so that we may fully discuss them.

ACKNOWLEDGMENT

I have read the above listed policies and I understand and agree to their content.

Client Name: _____

Client Signature: _____ Date: _____

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Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your written authorization. To help clarify these terms, here are some definitions:

1. "PHI" refers to information in your health care record that could identify you.

2. "Treatment, Payment, and Health Care Operations"
   a. Treatment is when I provide, coordinate or manage your healthcare and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another mental health clinician.
   b. Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
   c. Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

3. "Use" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
4. "Disclosure" applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.

5. Authorization" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversation during a private counseling session, which I have kept separate from the rest of your record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

1. Child Abuse – If I know or have reasonable cause to suspect that a child known to me in my professional capacity has been or is in immediate danger of being a mentally or physically abused or neglected child, I must immediately report such knowledge or suspicion to the appropriate authorities.

2. Adult or Domestic Abuse – If I believe that an adult is in need of protective services because of abuse or neglect by another person, I must immediately report this belief to the appropriate authorities.

3. Health Oversight Activities – If the DC Board of Psychology is investigating me or my practice, I may be required to disclose PHI to the Board.

4. Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about the professional services I provided you and/or the records thereof, such information is privileged under DC law, and I will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

5. Serious Threat to Health or Safety – If I believe disclosure of PHI is necessary to protect you or another individual from a substantial risk of imminent and serious physical injury, I may disclose PHI to the appropriate individuals.

6. Worker's Compensation – If I am treating you for Worker's Compensation purposes, I must provide periodic progress reports, treatment records, and bills upon request to you, the DC Office of Hearings and Adjudication, your employer, or your insurer, or their representatives.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:

1. Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

2. Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)

3. Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. You may be denied access to Psychotherapy Notes if I believe that a limitation of access is necessary to protect you from a substantial risk of imminent psychological impairment or to protect you or another individual from a substantial risk of imminent and serious physical injury. I shall notify you or your representative if I do not grant complete access. On your request, I will discuss with you the details of the request and denial process.

4. Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

5. Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

6. Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

1. I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

2. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

3. If the therapist intends to revise his/her policies and procedures, he/she must describe in the notice to patients how the therapist will provide patients with a revised notice of privacy policies and procedures (e.g., by mail, by e-mail).

V. Complaints

If you are concerned that I have violated you privacy rights, or if you disagree with a decision I made about access to your records, please make me aware of your concern.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on **January 1, 2022**.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a written revised notice.

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I, _____, a client of Dr. Ernest ("Tyger") Latham, received the HIPAA Notice of Privacy Practice. I have been informed that, should I have any questions regarding this Privacy Policy or do not understand the information in the Notice, I may direct these questions to Dr. Latham.

_____ _____

Signature Date

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I, _____, a client of Dr. Ernest ("Tyger") Latham, Psy.D., understand that I am financially responsible for payment of all services rendered. Please charge my credit card in the amount equivalent to **$220.00** per session (or **$250.00** per couples session) in the event that I do not reconcile my bill within a one (1) month of receipt.

Client Name: _____

Cardholder's Name (as it appears on the card):_____

Credit Card Billing Address (address that the credit card statement is mailed to):

Address Line 1: _____

Address Line 2: _____

City, State, Zip Code: _____

Credit Card Type: VISA MASTER CARD

Credit Card #: _____

Card Verification Code (3-digit number located on back): _____

Expiration Date: _____

Signature: _____ Date: _____